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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

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| DARTMOUTH-HITCHCOCK CLINIC, ET AL | * | 11-CV-358-SM |
| v. | * | January 11, 2012 |
| | * | 1:40 p.m. |
| NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES, COMMISSIONER | * | |

TRANSCRIPT OF EVIDENTIARY HEARING
AFTERNOON SESSION
BEFORE THE HONORABLE STEVEN J. MCAULIFFE

APPEARANCES:

For the Plaintiffs:
William L. Chapman, Esq.
Orr & Reno, P.A.

W. Scott O'Connell, Esq.
Gordon J. MacDonald, Esq.
Emily Pudan Feyrer, Esq.
Anthony Galderi, Esq.
Nixon Peabody, LLP

For the Defendant:
Nancy J. Smith, Esq.
Jeanne P. Herrick, Esq.
Laura Lombardi, Esq.
Office of the Attorney General
Civil Bureau

Court Reporter:
Susan M. Bateman, LCR, RPR, CRR
Official Court Reporter
United States District Court
55 Pleasant Street
Concord, NH 03301
(603) 225-1453

I N D E X

P R O C E E D I N G S

THE COURT: Mr. MacDonald, whenever you're ready.

CONTINUED DIRECT EXAMINATION OF KATHLEEN DUNN

BY MR. MACDONALD:

Q. Good afternoon, Ms. Dunn. Before we broke we were talking about a series of rate reductions which were presented by Commissioner Toumpas to the joint fiscal committee on February 5, 2010, and we've covered -- before the break we covered two of them, one of them relating to outpatient radiology and the second to what's called revenue code 510. I would now like to turn to the issue of outpatient cost settlement.

As I understand the way it works, outpatient services are paid on a cost basis, is that correct, for the most part, with some exceptions?

A. Correct.

Q. And the actual costs are subject to an audit or a review by a fiscal intermediary?

A. That's correct.

Q. Is that correct?

A. That is correct.

Q. And after the intermediary's work is done, then a final cost settlement is made; is that correct?

A. Correct. The state compares the amount of reimbursement that the hospital has already received through interim payments as compared to what the fiscal intermediary determined, and the delta between the two is the cost settlement payment.

Q. Okay. And if a hospital has been underpaid, after the settlement process the state will pay the difference --

A. Correct.

Q. -- of the underpayment; is that correct?

A. Correct, sir.

Q. And as I understand it, if the state -- if the hospital has been overpaid, the hospital needs to pay back the state the amount of the overpayment; is that correct?

A. That's correct.

Q. Okay. So the issue that the commissioner presented to joint fiscal on February 5th dealt with the former situation. In other words, where the hospitals were owed money after the cost settlement process; is that right?

A. That's correct.

Q. Okay. And we took a look before the break at your March 1, 2010 letter to Mr. Ahnen, and it's helpful because you describe in there what public

process and state plan amendments are required for the various rate reductions that were presented by the commissioner on February 5th.

And I would like to go to the second page of your letter and take a look at the chart, and the second line up is the issue we're dealing with and it says: Delay Medicaid outpatient cost settlement payments. And then you say that a public notice and state plan amendment are planned.

Now, did the -- I think it's accurate to say that a state plan amendment with respect to outpatient cost settlements was never fought; isn't that correct?

A. I don't believe that's correct.

Q. Okay. You have the outpatient pages in front of you. Why don't you go through and tell me which state plan amendment authorized the delay of outpatient cost settlements and was filed in -- let me put it this way. Do you agree a state plan amendment was necessary?

A. At the time this was a delay there was a possibility that we would still be able to make payments. And in fact in state fiscal year, later in the year, we were able to make payments -- the cost settlement payments for those hospitals whose cost settlement process had been completed.

Q. I understand. My question is: If the cost settlements are going to be delayed, that required a state plan amendment, didn't it?

A. Not a delay. It would have to be paid within the state -- the Medicaid state rate year. If we were not going to pay those cost settlements, then a state plan amendment would be required.

At the time of this March 1st letter I did not know that we were going to have funds later in 2010 to actually make the 2010 payments.

Q. But you told CMS the state plan amendment was required, didn't you?

A. We told CMS at the time that we were planning on putting a state plan amendment forward and if in the course of business we find out that it's not needed, then we don't pursue it.

Q. Does the state -- has the state continued its policy of delaying outpatient cost settlements?

A. Yes, it has, sir.

Q. And it's extended into this biennium, in other words, fiscal 12 and 13; isn't that right?

A. That is correct.

Q. Okay. And no state plan amendment was filed; isn't that right?

A. I need to actually look at this, and it might

be more efficient to ask one of my colleagues who is more familiar with the state plan. But I thought that if we were not going to pay those payments we would have included it in a state plan amendment, sir.

Q. I'm sorry. I did not hear that answer.

THE COURT: She doesn't know, but someone else knows.

A. I'm sorry. I'm trying to rifle through this very quickly and be efficient. I would expect that if we were not going to make those payments that we would submit a state plan amendment, sir.

Q. Okay. And a state plan amendment hadn't been filed with -- strike that. In recommending the -- or in notifying the joint fiscal committee that the department was going to be delaying outpatient cost settlements the department didn't undertake any analysis with respect to its effect on beneficiaries or providers or cost of care or access to care; isn't that right?

A. I believe we did.

Q. The action was taken in response to a need to cut the budget; isn't that right?

A. Yes, sir.

Q. Okay. Now, let's go on to catastrophic payments. And again, these cuts, like delaying

outpatient cost settlements, were driven by the need for the department to cut its budget; isn't that right?

A. Yes, sir.

Q. And was a state plan amendment required to delay Medicaid catastrophic payments?

A. For a delay of the catastrophic payments --

Q. I mean to suspend. To no longer pay catastrophic payments. I'm sorry.

A. I believe it was.

Q. And was one cut?

A. I believe it was.

Q. Okay. And was there public notice?

A. As part of the state plan process? Yes, sir. If we filed a state plan amendment, we automatically would do the public notice.

Q. I just show you Exhibit 36. Do you recognize Exhibit 36?

A. Yes, I do.

Q. Paragraph 2, I believe, addresses catastrophic payments?

A. Yes, it does, sir.

Q. And the public notice was published on February 26, 2010, and it asks for comments by March 15, 2010; is that right?

A. I'm going to say yes on the March 15th because I'm not going to read this fast enough. So, yes, comments were requested.

Q. Okay. Let's move to the topic of UPL payments which has been discussed quite a bit during this case, and can we agree that UPL payments are authorized under the Medicaid Act and they're intended to fill the gap between the rate that providers are paid and a ceiling set under the Medicare Act? Is that a fair representation?

A. Yes, sir.

Q. Okay. And in 2010 the state paid hospital providers upper limit payments on both inpatient and outpatient services; isn't that right?

A. Yes.

Q. And as you know, the plaintiffs in this case have said that the -- let me ask you this. That payment occurred in fiscal -- occurred in calendar 2010, fiscal 2011; is that right?

A. Correct.

Q. And in fiscal 2012, calendar 2011, there was no such upper payment limit payment; is that correct?

A. That's correct.

Q. And my understanding of the state's position in the case is that the -- and let's just use fiscal

year just to be clear. That the UPL in fiscal 11 -- that payment was a one-time payment; is that right?

A. That is correct.

Q. Okay. And I will assume, because the state takes that position, that it did none of the analysis required under the Medicaid Act in terms of analyzing whether withdrawing UPL payments were consistent with its obligations under the Medicaid Act; is that correct?

A. That's correct. It was not required.

Q. And because it was a one-time payment the state didn't need to undertake anything with respect to Section 13(A); is that correct?

A. No. That's not correct.

Q. How is that incorrect?

A. Because, sir, the reason the state for the very first time in state fiscal year 11 did that UPL payment was to take advantage of an enhanced match that was available under the American Recovery and Reinvestment Act. In fact, it was a recommendation that came from the consultant, Health Management Associates, that the hospital association had engaged.

When we did the state plan amendment to include it as part of uncompensated care payments, we made a point of leaving it in the state plan just in

case. So at that point there were rumors that ARRA was going to be extended. And if it was going to be extended, then we would take advantage of it the following year. It turned out ARRA wasn't extended and as a result, in making the change for this state fiscal year we have in fact filed a state plan amendment following appropriate procedure.

Q. Okay. Because when the UPL payments were made in fiscal 2011 --

A. Yes, sir.

Q. -- a state plan amendment was required, correct?

A. That's correct.

Q. Because the methodology was changing?

A. The entire DSH and uncompensated care methodology changed.

Q. And that's when you filed a state plan. And let's take a look at 4 -- in Exhibit 2, 4.19 B, page 1, the reimbursement page, and let's look at transmittal number 10-014.

So again, transmittal number 10-014, this was submitted in calendar 2010 to facilitate the UPL payment in fiscal 2011; is that right?

A. That's correct, sir.

Q. And it has an effective date of November 19,

2010?

A. Yes, it does, sir.

Q. And the redline -- this is a redline version, and it shows the change that's made on this page as compared to the previously affected page; is that correct?

A. Yes, it is, sir.

Q. Okay. So let's look at the third sentence -- or actually, let's start at the beginning: For outpatient services provided in calendar year 2010 an annual Medicaid payment adjustment shall be made.

Then the third sentence: This annual calendar year adjustment payment will be made in the final calendar quarter of each year until such time as it may be amended under the state plan.

So this was not a one-time payment. The state plan provided for annual UPL payments, didn't it?

A. No. I disagree, sir. It says: Until such time as it may be amended under the state plan.

It was always clear to the department and the plaintiffs what we were doing, why we did it. If we had not put this language in, sir, if ARRA had passed, it would have delayed our ability to make UPL payments in the current fiscal year.

Q. Well, in order to -- and obviously you're able to talk about -- well, strike that.

In order to accommodate the state's lack of payment of the UPL in calendar 2011, fiscal 2012, the language before you had to be changed, didn't it?

A. It did because of the methodology changing.

Q. And, in fact, I'll give you Defendant's 195.

MR. MACDONALD: It's ID, but we'll stipulate to its admission.

THE COURT: 195, any objection?

MS. SMITH: No. I agree it can be full.

THE COURT: ID may be stricken on Defendant's 195.

(Defendant's Exhibit 195 Admitted)

Q. Now, do you recognize this document?

A. Yes, I do.

Q. And what is it?

A. This is a transmittal notice for a state plan amendment filed in 2011. It is a companion piece to a different state plan that both speak to how uncompensated care payments were going to be made under the state plan amendment.

Q. Okay. And the --

A. State plan.

Q. I'm sorry. The companion state plan

amendment deals with inpatient services. This deals with outpatient services.

A. Outpatient, right. You have to file two separate ones.

Q. Okay. Thank you. So we see here on this transmittal notice there's a proposed effective date of December 14, 2011. And then let's scroll down to the redline version of page 1. There you go. Okay.

Now, we see a couple of things going on here. But if you look at the first sentence we see that -- of paragraph 3, we see that the words "in annual" are stricken; is that correct?

A. That's correct.

Q. And then if we look at the third sentence we see that "annual" is stricken and "each year" is stricken, and the rest of that sentence is stricken in lieu of the words calendar year 2011.

THE COURT: 10.

Q. 10. I'm sorry. So the state plan had to be amended to strike out the words "annual", didn't it?

A. Yes, it did.

Q. Okay. Now, I would like you to take a look at the, while we're on this page, the redline -- redlining of the paragraph above that.

Now, that's the language, isn't it, that the

state had relied on with respect to both revenue code 510 and outpatient radiology; isn't that right?

A. Initially, yes.

Q. Okay. And that language is now out of the state plan, correct?

A. That is correct.

Q. And if we remember the commissioner's letter of last week, he promised that that state plan would be withdrawn, and it looks like the state actually had done that effective December 14th. Am I reading that correctly?

A. No, sir. I'm sorry. You're not. The effective date of December 14th is the date that we would want CMS, once they approved this page, to go back to. That date is important because December 15th is the day we made DSH payments to the critical access hospitals.

This particular paragraph, which goes back to the rev code 510 issue, CMS informed us as part of their process of working with the state that the 08-017 state plan amendment was not needed for two reasons. One, the 510 billing was never allowed in the first place under the state plan, and the issue with the outpatient radiology I believe I explained. We thought we could be -- we could implement the fee

schedule, make the program more efficient.

After the financial management folks at CMS looked at it they asked the benefits folks to look -- excuse me -- the benefits staff at CMS to look at it. It was not until that point, which was very recent, that we understood that they would not approve the fee schedule for outpatient radiology if we wanted to maintain those services as hospital outpatient services.

As a result, each of these state plan amendments builds on the other, and so that strikes this language from this specific most recent state plan amendment.

Q. Okay. I want to show you -- get back to the UPL issue, okay?

A. Sure.

Q. Let me show you what's been identified as 196 for ID. That's Defendant's Exhibit 196.

MS. SMITH: You can strike the ID.

THE COURT: The ID may be stricken on Defendant's 196.

(Defendant's Exhibit 196 Admitted)

Q. Now, these are a series -- they appear to be a collection of public notices, and I would like to go to the one dated November 24, 2011.

Okay. In the package are a series of public notices, including the one on the screen now which was published on November 24, 2011, in the Nashua Telegraph. And the next page is one that appears to have been published on November 28th in the Union Leader.

And in the public notice -- it's a bit hard to read, but if you go down -- go down a little bit more. Okay.

Here we see that the state is saying: Additionally, the state plan will be amended to -- it's in the first full paragraph on the screen, last sentence: Additionally, the state plan will be amended to remove the upper payment limit, UPL, language that is no longer relevant as described in the October 31, 2011 notice.

And if we scroll down to the end we see that the copies of draft state plan pages will be on file at the department, and the draft pages are expected to be available on December 1. Once they become available, comments will be accepted for two calendar weeks after the date of availability.

When were the state plan amendment pages available?

A. I believe they were available December 1st.

Q. Okay. And so anyone interested in commenting on the elimination of the language with respect to UPL had two calendar weeks, which would take you to December 15th, which was a day after it became effective, is that right -- the state plan amendment changes became effective?

A. Yes, sir.

Q. Okay. Now, let's go back -- since this notice references an October 31st notice, let's go and take a look at that. Let's go to the one in the Telegraph again. It's a bit easier to read. The last paragraph on the portion that's -- well, go down. There you go. This public notice generally discusses changes -- by the way, strike that, what was the effective date of the budget this year for fiscal 12?

A. July 1 of 2011.

Q. Okay. Going back to the notice, the 2010 UPL payment was not anticipated to be made in years other than 2010, and therefore there is no fiscal impact associated with this.

The notice then goes on to describe fiscal impacts amounting to $158 million. Is it your testimony that the elimination of UPL payments resulted in no fiscal impact of the state?

A. No. Excuse me. Yes, it is. The UPL

payments in 2010 generated $20 million extra that went out to the hospitals.

In 2011 the aggregate amount of money available to make DSH payments was going to be the same regardless of whether we did UPL payments or DSH payments.

Q. But you are telling the public that as a result of the budget cuts there will be an estimated decrease in annual aggregate expenditures of $158,963,135 in federal fiscal year 2012; is that correct?

A. That's correct. Because the funds would not be on the UPL side of the payment methodology, and therefore, relative to that specific change, that's how much money was impacted.

Q. Okay. Do you know Keith Hearle?

A. I have just met the gentleman, yes.

Q. Who is he?

A. I know that he is a consultant that was retained by the Department of Justice and has expertise in hospital finances.

Q. Did you meet with him?

A. No, I did not meet with him. I had a conference call with him.

Q. Who else was on the conference call?

A. Nobody. The two of us.
Q. So you had a telephone call with him.
A. I'm sorry. When we -- I was traveling at the time so I used a conference call number.
Q. I see.
A. I had a telephone call with Mr. Hearle.
Q. And what did you discuss with Mr. Hearle?
A. I recall that Mr. Hearle was asking me some background questions on the state Medicaid program and then asked questions relative to how we had redesigned our DSH program, asked me questions about the rate reductions. It was all background information.
Q. How long did the telephone call last?
A. That phone call lasted somewhere between a half hour and an hour. I don't recall, sir, the exact amount of time.
Q. Did you have any other communication in any form with Mr. Hearle?
A. None whatsoever.
Q. Did you tell Mr. Hearle that it was the intent of the state to make UPL payments only once?
A. Yes, I did. And I explained why.
Q. So you felt comfortable speaking on behalf of the state in expressing what the intent of the state was?

A. Yes, sir.
Q. You had felt comfortable expressing the opinion of the Governor and the legislature and 424 members of the state legislature, I take it?
A. No. I felt comfortable responding to those questions as medicaid director for the state with the understanding of how I thought the program was going to be implemented in this current state fiscal year.
Q. Did you tell Mr. Hearle that a state plan amendment would be required to change the UPL methodology?
A. I believe -- if he asked that question, then I would have answered yes.
Q. Did you tell him that, though?
A. I don't recall, sir.
Q. Okay. Let's take a look at Exhibit 45. Exhibit 45 appears to be another PowerPoint presentation, or a series of slides, this time presented to the house finance -- Division III of the House Finance Committee; is that right?
A. Yes, sir.
Q. And Division III deals with the Department of HHS; is that correct?
A. Yes, sir.
Q. And this is dated February 7, 2011. And did

you help prepare this?

A. Yes, I did, sir.

Q. And did you actually appear before Division III on February 7, 2011?

A. Yes, I did.

Q. I would ask you to look at page 7, please. What was the purpose of your presentation to Division III?

A. Well, similar to the one in Senate, we had a group of new legislators so we did an educational session with both bodies. After the first -- there were three educational sessions with the House. After the first one we came back on this date to do some follow-up.

On the previous date when we were there we didn't have a chance to talk about disproportionate share payments, so we did this presentation, and subsequently they asked us to actually do a much longer presentation.

Q. Thank you. So here you are presenting to Division III some background on the disproportionate share hospital program, otherwise known as DSH, and the first bullet point says that DSH payments provide financial assistance to qualifying safety net hospitals that serve a large number of low income

patients, such as possible with Medicaid and the uninsured. It's existed since 1981. And then the second dash down says: Medicaid is included in uncompensated care because payments frequently do not cover the costs of care provided. And that's an accurate statement, isn't it?

A. Yes. It's often referred to as Medicaid losses.

Q. Now, the next bullet point: Over the years national policymakers have grappled with a variety of issues regarding Medicaid DSH. And you recite a rapid growth in spending. I take it that's on a national basis.

A. Yes, sir.

Q. And it says that there is concern with inappropriate targeting and use of DSH funds. What are the concerns or the issues surrounding the inappropriate targeting and use of DSH?

A. In this specific context it had to do with the fact that the ACA was looking at -- excuse me. I should use the whole acronym. The Patient Affordable Care Act has language in it that requires the Secretary to actually do a significant reduction in the DSH program.

And one of the questions New Hampshire

received was did we -- they wanted us to tell them why we had designated all of our hospitals as DSH hospitals. That's not a common practice. And we were asked that inquiry. And then we got into the conversation with them that went on to talk about what New Hampshire specifically was being looked at back in 2004.

Q. And the DSH program was under intense scrutiny by CMS; is that right?

A. Yes, sir.

Q. In New Hampshire?

A. In New Hampshire. Other states as well, but I can only speak to New Hampshire.

Q. Okay. Let's go to slide 12. Slide 12 says: Up until October 2010, a hospital's DSH payment for uncompensated care provided equal the MET paid by an individual hospital.

A. That's correct.

Q. And the MET is the Medicaid enhancement tax payments that hospitals are required to make under state law; is that right?

A. That's correct.

Q. And then you describe a major effort to reform the DSH program, and you cite to an OIG audit of 2004. And there was an OIG audit of New

Hampshire's Medicaid program; is that right?

A. That's correct, sir.

Q. And what was the result of that audit?

A. The results of that audit were that the Office of the Inspector General's opinion provided to CMS was that the state had overpaid hospitals -- had overpaid in DSH payments to the hospitals, and that in doing so we owed -- the state owed the federal government $35 million in a disallowance. That report went to CMS, and then it becomes CMS's responsibility to decide what action to take after that.

Q. Okay. Let's go to slide 17. This is captioned "The Uncompensated Care Calculation".

A. Uh-huh.

Q. And DHHS can only reimburse up to the amount of a hospital-specific DSH limit. And that's based on the cost of inpatient and outpatient services provided by each hospital, and it includes Medicaid losses?

A. Uh-huh.

Q. Which is the difference between Medicaid loss, cost, minus what hospitals get paid; is that correct?

A. Yes, it is, sir.

Q. Let's go to slide 19. Now, this is a little bit hard to read, but this shows the history of the

DSH program in New Hampshire in terms of DSH payments made, tax payment, meaning the payments made by the hospitals under the MET, and then what was generated for the general fund; is that correct?

A. That's correct.

Q. And if you look at the subtotal as of November 19, 2010, it's almost $1.8 billion.

MS. SMITH: I just don't know where we're going with this. I don't know how it's relevant to any decrease in DSH or MET that's at issue in this lawsuit.

THE COURT: Well, I agree. I can't help you with -- Mr. MacDonald, why is it relevant?

MR. MACDONALD: I'll move on.

Q. Let's take a look at Exhibit 47. Do you recognize this document?

A. Yes, sir.

Q. What is it?

A. It's a document that the Department of Health and Human Services utilizes as a reference document with the legislature when they are considering our budget.

Q. Okay. And it says -- it's another presentation to Division III, and it says on the front page that HHS was requested to present to Division III

various options to reduce general fund demand for fiscal years 12 and 13, and that this -- by up to $200 million; is that right?

A. That's correct, sir.

Q. And that's -- the purpose of this document is to present some options; is that correct?

A. This document was married to a spreadsheet very similar to the one -- oops, I'm sorry. I just spilled the water there. Very similar to -- I'm sorry -- very similar to exhibit what was 199. It was married to a spreadsheet like that.

And so what this larger document did, sir, No. 47, was to -- why don't I fix that. I'm sorry. I apologize.

MS. SMITH: Why don't you just take a break and deal with that.

THE WITNESS: I almost have it. Thank you. I'm very sorry, counsel. I'm very sorry.

THE COURT: It's not a problem. Don't worry about it.

A. So I was saying that this is a companion document to that spreadsheet so that -- what the House had requested was they wanted to be able to have a reference document that they could look up a particular budget reduction and use it as part of

their decision making process.

Q. Okay. Let's scroll through this document, and you've got the physical document in front of you.

A. Yes.

Q. And do you see the spreadsheet you're talking about, pages 2, 3 and 4?

A. Yes, sir.

Q. Okay. So that's the spreadsheet on the screen. I would like to go to the first page of text. It's page 8 of 84, and is this part of the -- I assume you did not -- you did not yourself create the entirety of Exhibit 47.

A. No, sir. I didn't.

Q. Did you participate in any of the preparation of this document?

A. Yes, I did, sir.

Q. And did you participate in the preparation of page 8 of 84, which is now --

A. I did, sir.

Q. Okay. And did you actually write this text?

A. No. It was drafted by one of my staff members. I reviewed it and approved it.

Q. Okay. And here we have a summary of a proposal, as I understand it, to eliminate uncompensated care funding all together; is that

correct?

A. That's correct.

Q. And it gives a brief summary of what the Governor had proposed in his budget.

A. Uh-huh.

Q. And then it describes this reduction as essentially directing all of the MET revenue to the general fund and eliminating the non-federal match required for the disproportionate hospital payments. And the effect would be essentially that the hospitals would continue to pay the MET but not get the DSH payments back; is that correct?

A. That's correct.

Q. Okay. And if we could just take a quick look at Exhibit 62, and here I would like to use the document camera. I'm presenting you with the actual Exhibit 62. Do you recognize Exhibit 62?

A. I do, sir.

Q. And what is it?

A. This was a spreadsheet that my office created in order to calculate -- not just calculate but also to share information with the hospitals in terms of the DSH payments that were made to the critical access hospitals in December.

Q. Okay. The spreadsheet, or at least the copy

we have, is a little hard to read, but let's just walk through it together.

Right here we have hospital name, and you would agree that those are the 26 acute care hospitals in the state of New Hampshire?

A. It also, I believe, includes two rehab hospitals. So it's the 26 plus the two rehabs.

Q. Okay. And the -- you're right, and I'm sorry. And the hospitals listed at the top of the page are the critical access hospitals; is that correct?

A. Yes, sir.

Q. And the hospitals at the bottom of the page are the non-critical access hospitals, correct?

A. Yes, sir.

Q. And they include the ten plaintiffs in this case?

A. Yes, sir.

Q. Okay. The next column is DSH category, and CAH means critical access hospital, correct?

A. Yes, sir.

Q. And for the non-critical access hospitals it says deemed TBD.

A. That's correct.

Q. And I believe that goes to an issue that came

up earlier today, and we'll get to that.

A. Okay.

Q. The next column is uncompensated uninsured care costs, and that, I take it, represents the state's data gathered from the individual hospitals about what their uncompensated care is for the uninsured. Is that a fair statement?

A. One slight clarification, if I may, counsel. It's the data that was reported to us by the hospitals, and we have summarized it on this spreadsheet.

Q. Okay. And the next column summarizes data about uncompensated Medicaid; is that right?

A. Yes, sir.

Q. Okay. And then the next column is total uncompensated care. Then the next column is DSH payment, and then the next column is the projected payment under the Medicaid enhancement tax; is that right?

A. No. Column G --

Q. Yes.

A. -- is the data that was gathered from the hospitals in terms of their reporting of their projected tax liability, their tax payment, and that's done by the Department of Revenue Administration.

Q. Okay. Thank you. And then the final column is captioned, Projected Net Position Based on Reported NPSR, and NPSR is net patient service revenue?

A. Correct.

Q. And this spreadsheet reflects DSH payments going out to critical access hospitals in the amount of $48,735,473; is that right?

A. That's correct.

Q. And those payments were actually made on or about December 15th of 2011?

A. Yes, sir.

Q. And then immediately below that you see that no DSH payments were made to the non-critical access hospitals, correct?

A. That's correct, sir.

Q. Subject to a holdback, it looks like, of $500,000; is that right?

A. That's correct, sir.

Q. And that $500,000 will be distributed to hospitals which are so-called deemed status hospitals; is that right?

A. That's correct, sir.

Q. So that the net is that that $500,000 will be distributed among some but probably not all of the critical access hospitals?

A. I would say it will be very few, actually, will meet the criteria.

Q. And that's a criteria set forth in CMS regulations; is that right?

A. Yes, sir.

Q. And the net position, the column on the far right, reflects the DSH payment less the amount that the hospital is paid in MET; is that right?

A. Yes, sir.

Q. Okay. And so the net for the critical access hospitals is roughly $25 million?

A. Yes, sir.

Q. You go down to the net for the non-critical access hospitals, it says it's zero, but I think we could agree that it's really a substantial number in the negative, isn't that right, because they are not receiving any DSH payments but are continuing to pay the MET?

A. For net position, yes, that would be true, sir.

Q. And I'll just represent to you, having done the math, and I won't spend the time on it, that as to the ten plaintiffs that number instead of zero should be $127,494,293.

MR. MACDONALD: And I believe -- has the

state agreed to this exhibit?

MS. SMITH: Yes. We stipulated to that exhibit.

MR. MACDONALD: Okay.

THE COURT: What's the number?

MR. MACDONALD: 62.

THE COURT: ID may be stricken on 62.

(Plaintiff's Exhibit 62 Admitted)

MR. MACDONALD: Okay. Can we go back to Exhibit 47 and the page we were on.

THE COURT: Again, I'm just confused about the MET. It's a tax imposed by the state that collects it, right? That's not an issue here?

MR. MACDONALD: No. I'm getting to it.

THE COURT: Okay.

Q. The proposal that you were discussing to the House Finance Committee, Division III, was to pay the MET but not get the DSH. And we see, if you scroll down, there's a section called Estimated Impact to Clients, Providers and Communities, and it says: Uncompensated care payments made to hospitals to provide compensation for inpatient and outpatient services provided to our state's uninsured. Last year the hospitals provided $299 million of uncompensated care and we were reimbursed $207 million, leaving

$92 million worth of care uncompensated. Elimination of the DSH funding will have a significant fiscal impact on hospitals in that it will downshift the financial responsibilities to the hospitals. Presumably the hospitals will pass some of these costs on to privately insureds through their contracts negotiated with insurance companies, thus resulting in a cost shift and increasing commercial health insurance premiums. However, not all hospitals have the capability to shift costs to commercially insureds due to the population that utilizes their services. There is a strong possibility that this reduction could result in a hospital's inability to sustain operations and therefore close; is that correct?

A. That's correct.

Q. And that's what you told the House Finance Committee?

A. That's what we told the House Finance Committee when they asked us about this particular option within the budget; yes, sir.

MR. MACDONALD: Your Honor, I pass the witness.

THE COURT: All right. Who is taking the witness? Attorney Smith?

MS. SMITH: We have one witness that we have

to get done today. We had agreed to start him at 3:00, and it's almost that. So rather than do 20 minutes of Ms. Dunn, I would prefer to call Mr. Hearle and then go back to Ms. Dunn when we get done.

THE COURT: That's fine with me if it's okay with you.

MR. O'CONNELL: It's all right.

THE COURT: Sorry, Ms. Dunn. We keep interrupting you.

THE WITNESS: That's okay. Should I just leave these here?

THE COURT: Oh, please.

MS. SMITH: The state calls Keith Hearle.

KEITH HEARLE

having been duly sworn, testified as follows:

THE CLERK: Would you please state your name and spell your last name for the record, please.

THE WITNESS: Keith W. Hearle, H-E-A-R-L-E.

DIRECT EXAMINATION

BY MS. SMITH:

Q. Mr. Hearle, could you please tell the Court what you do for a living?

A. I have a consulting firm based in Alexandria, Virginia, that focuses in on hospital finance, healthcare policies as it relates to hospitals, the

community benefit obligations/expectations of hospitals that are tax exempt, and those types of matters.

Q. And were you retained in this case to look at information related to the complaint of the hospitals in this lawsuit?

A. I was.

Q. And have you prepared a report that you provided to the state?

A. I did.

Q. And there are some white notebooks back there, and we'll also get it on the screen in front of you. Is your report what we've marked for identification as Exhibit 200?

A. Yes. That's the one.

Q. Maybe I can shorten the questioning a little bit. The first four pages of your report summarize your qualifications, correct?

A. They do.

MS. SMITH: And is the plaintiff going to have any objection to Mr. Hearle being qualified as an expert?

MR. O'CONNELL: We have no objection to him being qualified. We only reserve rights to object to some opinions.

THE COURT: All right.

Q. And what were you asked to look at and what were you asked to provide opinions on in this case?

A. I was asked to review certain financial information contained in declarations provided by the hospitals, other financial information that is publicly available, to review other documents, certain testimony, to interview Ms. Dunn, and to prepare the report.

Q. And did you provide in your report a list of all of the things that you looked at that went into forming your opinions?

A. I did. That is listed in Exhibit A to the report. However, I also have looked at some recently submitted information, supplementary declarations, those types of things.

Q. What are the conclusions -- did you state in your report the conclusions that you have reached as a result of the work that you performed?

A. I did. Those conclusions are summarized on page 8 of the report. The first conclusion is regarding some of the values reported in the declarations.

There are numbers regarding Medicaid payment, Medicaid cost reported by each of the hospitals, and I

spent some time trying to validate those numbers by comparing them to similar numbers reported in other data sources. And the first conclusion is that it was difficult to validate those numbers that were filed with the original declarations.

Q. We talked about some of this -- you talked about some of the specifics that you looked at further in the report, correct?

A. I do.

Q. Okay. We'll come back to that. I just want to get the general conclusions out first.

What was the next conclusion you reached as a result of the information you reviewed?

A. The second -- when I was reviewing the original declarations, I was uncomfortable with the way that the rate impact information was presented, specifically with respect to the upper payment limit funding not being shown as an offset to some of the other rate actions that the state implemented, and then how it was reported in years when it no longer became available.

Q. And what other conclusions did you reach?

A. I compared the profit levels of hospitals in New Hampshire to profitability of hospitals in other states and found that historically the hospitals in

New Hampshire have been more profitable than others in New England.

MR. O'CONNELL: Your Honor, we object to that opinion and would ask that it be stricken. It has no relevance to the analysis before the Court. The Court has heard about what the standard is for 30(a), 13(A), and profitability is not among those standards, and a comparison to hospitals outside of New Hampshire has no relevance on your analysis of this case.

THE COURT: Well, I think it actually is relevant. It goes back I think to your own contention that these rates are violative of 30(a) in that they aren't sufficient to provide access to available medical services and so forth. And your position is, sure they are if they use their profits to subsidize them, right?

MS. SMITH: That's correct.

THE COURT: Objection overruled.

MS. SMITH: And also testimony that the department did consider the impact on access by looking at the hospital's profitability. It validates that.

THE COURT: I mean, New Hampshire hospitals in gross versus Massachusetts' hospitals in gross isn't particularly persuasive evidence, but to the

extent it's relevant, it's relevant.

Q. And what other conclusions did you review -- reach as far as the hospitals' sources of losses?

THE COURT: When you say the hospitals, who are you talking about, these plaintiffs as compared to --

MS. SMITH: The plaintiffs' sources of losses.

MR. O'CONNELL: Well, that's not actually what the report says, your Honor, but I can take that up on cross-examination.

A. I concluded that the hospitals in New Hampshire on average have fewer Medicaid patients in their payer mix, but that also the hospitals are struggling both with Medicare losses in addition to Medicaid losses. So financial challenges are not only associated with Medicaid.

Q. And I think the last conclusion that you stated in your report was in relation to community benefits, correct?

A. It is.

Q. Do you have a particular expertise regarding the community benefits field?

A. I do. I participated in work with the Catholic Health Association in the late 1980s to

develop the first accounting and reporting framework for community benefit.

If you fast forward to the most recent periods, I've been working directly with the IRS on how to report community benefit in what's known as IRS form 990, Schedule H. I've worked with them on instructions to that form, have worked with Senate Finance Committee staff as they've considered the evolving standards that hospitals need to meet -- exempt hospitals need to meet at a federal level to keep qualifying for that exempt status.

Q. And what was your conclusion regarding -- what conclusions did you reach regarding these hospitals' actions in relation to their community benefit reporting?

A. The conclusion is that tax exempt hospitals like the plaintiffs have an expectation that they provide community benefits, and that expectation is at a state level and at a federal level. The amounts to be provided have not been specified anywhere in federal law or regulations. However, there is a presumption that to be tax exempt in return for those tax benefits, not paying income tax, property tax, those types of things, certain community benefits are to be provided, and those include providing Medicaid

services at a loss, providing charity care that is not fully reimbursed, those types of activities.

Q. Okay. Going to the specifics, supporting those conclusions, don't you lay those out in the rest of your report, correct?

A. I do.

Q. Turning to the first of those, which is your analysis regarding -- looking at the financial -- was that in regard to financial declarations that were given to you that the plaintiffs had submitted in support of their pleadings for the summary injunction?

A. That's correct. I believe those were filed in July, August 2011, something like that.

Q. And you've been provided the subsequent declarations that have been filed since then?

A. I have.

Q. What did you do to try to validate those declarations?

A. The first thing was to enter all the numbers into a spreadsheet and then to pull together comparative information from three sources.

The first being IRS form 990, Schedule H, which I know quite well having done as much as I have with the Service on that particular reporting framework.

The second is community benefit reports that the hospitals file with the state of New Hampshire.

And the third is Medicare cost report information that the hospitals file with the state to claim Medicaid outpatient reimbursement.

So I organized all those three resources together and looked to see if the numbers originally filed aligned with those other data sources.

Q. And what are your conclusions?

A. The conclusions are that there are some differences, there are some variances between the data sources, and the variances would be easier to understand if the methodologies for putting costs to Medicaid services -- the sources of the information were better disclosed or outlined in the original declarations.

Q. Did you set forth your comparison in various tables in the report?

A. I did.

Q. Can you go through those tables and tell us what they are and what conclusions you drew from each of those tables?

A. Table 1 contains values from the original declarations. We have Medicaid cost for each of the hospitals for 2009 and 2010, the Medicaid payments for

those same two fiscal periods. The difference being the reported Medicaid loss in the declarations for all of the different categories that have been discussed, inpatient, outpatient, psych ward, that was in, all the different categories that are covered in the declarations.

One conclusion from this table is that hospitals are losing money on their Medicaid rates. I didn't put totals in this table. If I had, the Medicaid cost numbers would be roughly 220 million for 2009, 250 million for 2010. The Medicaid payment numbers are roughly a hundred million in each of those two years, and so the difference is a loss that the hospitals incur when they serve Medicaid patients and get reimbursed based on rates in the state. So those are conclusions from table 1.

Table 2 compares Medicaid losses -- presents Medicaid losses as reported in most recent IRS form 990, Schedule H filings by hospital. And what we see here is that the losses and the declarations for I believe seven of the ten hospitals are greater than the losses reported in Schedule H. For three of the hospitals the losses are lower in the declarations than what appears in Schedule H.

And I'll just give you some examples. The

loss for Mary Hitchcock Memorial Hospital, 52 million for 2009, 71 million for 2010. When we go to Schedule H, that number is roughly 39 million for its fiscal 2010.

Now, there are some reasons why a variance like this might occur relating to the organization that's actually filing the 990. It may be that the physician group is outside of that 990. But again, these are explanations that could be better laid out in the information submitted by the plaintiffs.

Q. And did you actually look at Southern New Hampshire to see whether the losses it claimed from other parts of its organization accounted for that variance?

A. I did. When we looked back at table 1 for Southern New Hampshire, the loss reported for 2010 is 12.6 million. When we go to Schedule H, it's 7.7 million. So I wonder, well, is it the physician practice that might account for the difference. And I could not account for the entire difference in that one category of Southern New Hampshire's activities, but it did explain a big chunk of the variance.

Q. And I think -- what did you look at that you refer to in table 3?

A. Table 3 summarizes what the hospitals

submitted to the state in their community benefits reporting forms, and we see similar variances between the declaration information and those community benefit forms as well.

Mary Hitchcock, for example, 2010 the loss is at 62.5 million. Going back to the declaration, it's 71.2 million. Again, there could be differences in what activities are covered by both reports, but the variances are not explained.

Q. And was there a trend in which direction the variances were -- which source of information claimed greater losses?

A. In general, the declarations reported the highest losses of any of these other sources. There is a significant difference for Southern New Hampshire. If we look at table 3, the reported loss is 2 million. The declaration is again 7.7 million.

Q. So these weren't just a few dollars off, some of them were millions of dollars off?

A. That's correct.

Q. And the fourth table you looked at Medicaid outpatient cost records?

A. I did. I requested data from the department which would be the actual Medicare cost report filings submitted to the department to claim the Medicaid

outpatient reimbursement. It is that Medicare cost report, plus another schedule, that gets submitted for that purpose.

And here on table 4 I'm comparing the outpatient cost figure reported in the declarations for Medicaid to the filings that are on file at the department used to actually claim the reimbursement. And some of them are very much right on the money, so it's clear that the hospitals relied on their cost report filings for that data source. But there are a few where we do see variances, such as Southern New Hampshire again, 5.3 million is the amount of cost in the declaration, where the cost report that was used to claim the reimbursement said 4.6.

Q. And you said you were asked to look at the supplemental declarations that have been submitted, correct?

A. Yes.

Q. I'm going to ask you to look at the ones regarding Mr. Lipman from LRGH. I think that's Exhibit 76 through 78. And if you can look at -- I think it's table 5 in the original declaration, which is 76, and how have the numbers in that changed in the declarations, and can you tell us any conclusions that you draw based on those changes?

A. Table 5 in Exhibit 76 portrays the originally estimated impact of rate reductions on Lakes Region Hospital. The amount when you tally it up across the 2008 through 2013 time frame adds up to 33.7 million.

When I saw this portrayal of the impact and saw this as a similar analysis across all of the hospitals, it raised that second concern that I mentioned at the beginning of my comments with respect to how the upper payment limit funds were reported.

That UPL funding of 4.6 million is presented in 2011 as a negative number when in fact it was a positive revenue source that came in during that one fiscal year for the organization. So that raised that as a concern in this part of the assessment.

Q. And how would you -- how do you think it should have been characterized? Should it have been characterized differently to be more accurate?

A. I would have characterized -- made two changes. The first is to reverse the sign on the UPL dollars for 2011, which of course swings that $33.6 million impact by $9 million.

The second I would do is to take the negative numbers in 2012 and 2013 and make them zero. What happens here is we have a positive amount of revenue coming into the organization in 2011. Then in 2012

and 2013 that positive revenue no longer is present. So you've reduce the positive impact to zero in those two years, and that's a fairer way to present the impact of the state's rate decisions.

Q. And comparing that initial declaration to the subsequent ones, what do the subsequent -- what impact do the subsequent declarations have on the conclusions that you've stated?

A. Looking at Exhibit 77, which I see was filed in November -- I don't believe this has the specific table that --

Q. Okay. I apologize. I have the numbers written as 76, 78 and 79 that I need to show you. I may have given you the wrong ones. If you could look at 78?

A. So looking at 78 --

Q. Does that have the revised declaration?

A. It does. It's a revised table 5. This table shows the UPL dollars for 2011 no longer being negative. It shows that as being zero. The total impact is reduced from 33.7 million from the previous table to 17.8 million.

Q. Let me show you what they have marked as Exhibit 79, which they've represented is a chart of Lakes Region's claimed losses. How does that differ

from Exhibit 78?

A. So in Exhibit 79 the upper payment limit dollars now are not negative. They are not zero. It's a positive 4.1 million. We still have negative numbers in for 2012 and 2013. I would argue that the impact on Lakes Region was positive 4.1 in 2011 and then zero in 2012 and 2013. So the bottom right-hand corner number would be the 11.6 million associated with the other rate reductions minus the benefit of the UPL funds for that one year, or roughly 7.5 million.

So the Lakes Region impact would go from 33.7 to 19 something to 15.7, and I would argue to 7.5 if this were portrayed in the way that I would view as more reasonable.

Q. Okay. So I think we've also covered your -- just to move this discussion along, we've also covered your conclusions regarding how the upper payment limit should have been portrayed on the financial declarations, correct?

A. Yes.

Q. Are you familiar with how UPL and DSH are paid in other states across the country?

A. Somewhat familiar. Not every state and not in great detail, but yes, I am.

Q. You've heard testimony I think that UPL is to fill the entire gap between what Medicaid pays and the upper payment limit. Is that what happens across the country, to your knowledge?

A. That is the maximum amount of payment that can be made by a state to bring the Medicaid rates up to the level of Medicare rates for similar services. So the upper payment limit is the Medicare rates. The amount that a state can provide for hospitals varies depending on the particular program and budget circumstances.

Q. And did you present a table where you portray what you think an alternate portrayal of the rate reduction should be in your report, and can you just point us to where that is?

A. I did. Table 5 of the report summarizes what was in the original declarations in terms of the rate reductions and the financial impact on the hospitals. It shows numbers ranging from 6 million for 2008 up to 99 million on an annual basis in 2013.

The upper payment limit number in 2011 is negative. Even though it was a positive revenue stream that came into the hospitals in that year, the numbers for 2012 and 13 are still negative. So I restated these numbers to reflect the concerns that

I've raised in table 6. Over time that takes the cumulative value of the numbers from what was stated as 310 million across the declarations to something more like 83 million.

The other observation I would have is I almost wish I had put a solid line in between 2011 and 2012. 2008 through 11, we can view that as history. And if we look at the cumulative numbers only through 2008 and 2011, I believe when you add in table 6, the negative 6, negative 17, negative 28, positive 34, all together we end up with a negative 17 million as the impact from 2008 through 2011.

Then upon thinking about it more, 2012 and 13 are projected numbers projected by the hospitals. All of these would be impacted if all of the patients remained in fee-for-service Medicaid. Many of them would not be going into managed Medicaid.

So there's a question that came into my mind about what happens when New Hampshire implements Medicaid managed care sometime in 2012, what kind of rates the plans will actually be negotiating with the hospitals and would those rates be based at all on the fee-for-service rates that are in question here.

Q. You opined that based on the information you have reviewed that the financial health of New

Hampshire hospitals was better than other national hospitals or similarly situated hospitals?

A. Yes. The Medicare cost report includes income statements and balance sheets for every hospital that files a Medicare cost report, and that's publicly available through CMS. So I downloaded all the cost reports for all of the hospitals in the country and summarized their financial information here on table 7.

What we have here is the total margin, the net income for each hospital aggregated to a state level. What this shows is that in 2009 New Hampshire hospitals had a total margin of approximately 5.1 percent. That compares to a New England average of 1.6 percent including New Hampshire, 1.3 percent excluding New Hampshire. So on that basis I concluded that historically the hospitals have been more profitable than neighboring hospitals in this part of the U.S.

Across the U.S. the overall total margin averaged around 6 percent. So slightly less than the U.S. average but healthier than other facilities in New England.

Q. And in table 8 you also looked at another source of information about hospital profitability?

A. I did. I reviewed audited financial statements filed with I believe it's charitable trusts in the Attorney General's Office and summarized operating revenue and operating income for each of the systems or organizations that are part of this complaint here in table 8.

So in 2009 we see that all -- each of the organizations did have a positive operating income reported. Overall, around $101 million of operating income. That's a different number than the net income. The difference being non-operating items, interest earnings and other categories of items. But the operating income was roughly 2.9 percent across the hospitals and healthcare systems in 2009.

In 2010 Lakes Region did report a negative operating income of 2.3, and two of the organizations had not yet filed the audited financials with the state.

Again, as I think about these numbers and I think about the DSH resource that may go to zero, if that truly is $130 million impact on the organizations, we put that in context with these operating income numbers and it clearly would be a significant impact on the hospitals in terms of their financial well-being.

Q. But this shows that up through 2010 at least almost all of the hospitals still -- just on their operating budget -- and they have other sources of income, as well, right?

A. Non-operating sources, correct.

Q. But just on their operating budget they were still generating a profit on their operating margins even after it went to these reductions that we've been talking about?

A. That's correct. These are after the rate reductions that have been discussed. So those rate reductions were, many of them, in effect in 2009 and in 2010.

Q. And you also talked about whether or not Medicaid was the only source of losses to the hospital. What did you review in that respect?

A. The community benefit filings -- the community benefit reports filed by the hospitals also include information about Medicare revenues and costs in addition to Medicaid revenues and costs. So table 11 summarizes what the hospitals submitted to the state in terms both of Medicaid and Medicare.

We've aggregated here -- it's one year of information for each hospital, different fiscal periods depending on the most recently filed

information. So the most recent information, whether it's fiscal 2011 or fiscal 2010, indicates that the hospitals collectively would have lost around 215 million from Medicare, around 136 million in Medicaid.

Q. So do I understand correctly that your review of the data that they have reported indicates that they are losing a lot more money from Medicare than they are from Medicaid?

A. That's correct. And the report explains one reason why that's the case. Medicare is a much larger payer for the hospitals in terms of patient population than is Medicaid. Medicare more like 43 percent. Medicaid more like 11 or 12 percent of the patient mix.

Q. Based on your experience with healthcare finance, does that size of Medicare losses raise any concerns in your mind?

A. It does raise a question, which is about the efficiency of the hospitals. Generally when -- Medicare is viewed as a reasonably accurate payer. Across the United States all hospitals collectively lose something like 7 or 8 percent on Medicare, but it's viewed as a more accurate payer than Medicaid is in terms of its allignment with the actual cost of organizations.

I noticed that the declarations included really no information on efficiency of the hospitals, which means that the claims are about the payment side of the equation, not so much the cost side of the equation.

Q. And your final conclusion related to the community benefits requirement. What are your conclusions and what are their bases in that regard?

A. The conclusions are that federal and state policies expect that tax exempt hospital organizations should provide community benefit, with community benefit defined as providing access to care, access to services, to help enhance public health, to help advance generalized knowledge, which is where health professionals education and research comes into the equation, and also to relieve government burden to improve health.

And I'm quoting text from the IRS Schedule H instructions where community benefit is defined at a federal level. It's well understood that providing charity care at some level of loss, providing Medicaid services at some level of loss, are important components of that community benefit.

When we look at the IRS form 990, Schedule H, there's a table that lays out all these categories of

community benefit, and these are the first two rows of that table, charity care and Medicaid services. So they're clearly important components of the community benefit that tax exempt hospitals provide.

And the expectation is that hospitals will provide these benefits in return for not paying property tax, federal income tax, sales tax, and they also enjoy other benefits like receiving charitable donations that are deductible to the donor and the ability to issue tax exempt debt, which is preferred.

Increasingly through time the expectations of organizations to provide these types of benefits have been increasing, which is why we now have the Schedule H and additional standards being offered at a federal level.

MS. SMITH: Thank you. I have no further questions.

THE COURT: Thank you, Attorney Smith. Mr. O'Connell.

MR. O'CONNELL: Yes. Thank you.

CROSS-EXAMINATION

BY MR. O'CONNELL:

Q. Good afternoon, Mr. Hearle.

A. Good afternoon.

Q. Did I understand your conclusion with regard

to table 1 is that the plaintiff hospitals are losing a lot of money on Medicaid?

A. That is one of the conclusions, yes.

Q. Losing a lot of money, but your point of differentiation is maybe not as much as represented in the declarations?

A. Yes. If we were to redo this table based on alternative data sources, the hospitals still would be shown as losing money but the amount would be different.

Q. Okay. Let's talk about those alternative data sources for a moment. You know that, for example, Dartmouth is a health system, right?

A. I do.

Q. And you were in the courtroom when we talked about Southern New Hampshire being a system with an affiliated medical physician practice, correct?

A. Yes.

Q. Lakes Region, same thing, true?

A. That's what I understand, yes.

Q. And you were in the courtroom when Exeter Healthcare talked about its program, which is also an affiliate of a hospital, correct?

A. I believe so, yes.

Q. Isn't it true that all of the additional data

sources you looked at are hospital only data sources?

A. Not entirely correct. The 990 is filed on an EIN -- by an EIN basis. EIN means employer identification number. And there are hospital organizations that include in their EIN non-hospital activities, like physician groups, like foundations, like ambulatory care surgery centers. It's probable that we have some non-hospital operations in some of the Schedule Hs that I reviewed.

Q. Did you ever look to find out if that was the case?

A. I did not go through that level of assessment.

Q. So you don't know as you sit here today whether Exeter, for example, includes the loss associated with Exeter Healthcare, its ventilator program, do you?

A. I wouldn't know that.

Q. In fact, wouldn't you agree that the better way to do the analysis that you tried to do for this Court was to look at the source data from the declarants?

A. I did look at the source data.

Q. The source data was the declaration, right?

A. Correct.

Q. But you're sitting here today and you don't know what assumptions they made or what data they used, correct?

A. That's because that information was not disclosed or included in the declarations themselves.

Q. Did you ever ask for it from the state? Did you ever ask to get that source data so that you could do your analysis?

A. I didn't know to ask the state for the information because the state wasn't cited as the source of the information in the declarations.

Q. Well, let me ask you it this way. If you were to do this as a consulting undertaking, you would agree that starting with the source data to determine what the ground rules were would be a more accurate way to determine whether there are problems with the data represented, wouldn't you agree?

A. I would want to start with the most accurate and complete source of information, and one of those sources is the cost of Medicaid. And there are different methodologies for cost accounting those activities. I would want to understand exactly what methodologies were used to assign costs.

Q. So you would like to know how the CFOs who prepared these declarations relied on their numbers,

how they got to their numbers, right?

A. I would like to know that, yes.

Q. But you went to other data sources that may not include the same data information to make their opinions here today. Isn't that true?

A. I went to the alternative sources to see if I could validate the numbers reported by the hospitals in their declarations and reached my conclusions after conducting that work.

Q. And you never did the level of analysis to know whether any of the ten plaintiffs' Schedule Hs that you looked at included their non-hospital Medicaid revenues or losses, did you?

A. I did not figure out if the systems had activities -- if they filed more than one 990 that captured other activities outside the ones that I reviewed.

Q. So there could be a pretty simple explanation for the discrepancies, a non-nefarious explanation, which is the hospitals just included more data than you had available to you from these other sources. Isn't that possible?

A. That's possible.

Q. By the way, on your Exhibit A you only reference looking at one of the Schedule Hs, that's

for Dartmouth. Is it your testimony you looked at others?

A. I looked at all of the Schedule Hs for all of the organizations.

Q. Is there a reason you didn't disclose that in your report?

A. I believe the "et al" after Dartmouth-Hitchcock -- the "et al" was meant to capture all of the other hospitals that I reviewed.

Q. Okay. Thank you for that clarification.

One of the reports that you relied on was generated by Steve Norton from the New Hampshire Center for Public Policies Studies here in New Hampshire; is that right?

A. I believe, yes, it was a cost shift report that has been issued more than once.

Q. And in fact his data, the information he relies on for that report, is based on the hospital systems, not just the hospitals. Isn't that true?

A. I believe that's true.

Q. And it's fair to say, too, is it not, that hospital systems, at least as they exist in 2012 in New Hampshire, subsidize unprofitable lines of business? Isn't that true?

A. The report indicates that there is cost

shifting from the Medicare program and the Medicaid program. Except for the critical access hospitals that have those costs reimbursed by virtue of their special status, those costs are -- those losses are shifted to the commercial payers. I believe the number reported in the 2011 report was something like $800 million worth of cost shift.

Q. Well, there are a couple different kinds of cost shift. There's the one you just described, which is trying to get the commercial payers to pay more than the cost. That's one, isn't it?

A. It is.

Q. But within the system itself there's the ability to take profits generated off of certain kinds of services with margin and subsidize other services that have a negative margin. Isn't that true?

A. That's very true. There's also a category of community benefit called subsidized health services, and basically the IRS would view those types of cross-subsidized services, like the Exeter unit that was discussed yesterday, that $3 million loss, that could be reported on Schedule H as a community benefit provided by that organization, if I understand the details of that program.

Q. So that's not a surprising or a new

revelation. That's just the way healthcare systems run.

A. It's a basic part of hospital finance. You take services where you make money, that may be cardiac care, and you use those profits to fund other services that the community needs.

Q. And so it's also true and well-known, is it not, Mr. Hearle, that if you take money out of a system and reduce the margin, the ability of a health system to subsidize a losing program is diminished? Isn't that true?

A. In a circumstance where a hospital has reduced reimbursement there are a range of actions that a hospital can take to address that change in their circumstances. One of them is to become more efficient, and many of the statements yesterday indicated that the hospitals were working to reduce staff, to do various things to become more efficient. They have the opportunity to reduce services, such as those that were discussed, different methodologies for addressing the reduction. Another is simply to accept a lower margin and to continue to operate on that basis.

Q. At some point a lower margin, if it's negative, is not sustainable. Isn't that true?

A. I would agree with that.
Q. So you heard a lot of testimony over the past two days about the efforts in efficiency, like layoffs, like voluntary retirements, like freezing of executive benefits, those type of things. Is that what you consider efficiencies?
A. Those are the types of things, yes.
Q. And at some point you reach the end of what you can do in order to get the benefit of more efficiencies. Isn't that also true?
A. I believe that's true at some point.
Q. At some point you push it too far and you don't have enough resources to do what you need to do. Fair statement?
A. That's a fair statement.
Q. So another option would be the cost shift, which we talked about, either internally from positive margin service lines or externally to the private payers, correct?
A. Correct.
Q. Now, as part of your undertaking in this matter have you reviewed any of the contracts that the ten plaintiff hospitals have here with any of their commercial insureds?
A. I have not.

Q. So that's an unknown to you as you sit here today, right, the ability to cost shift to the private payers, because you haven't done that analysis?

A. I haven't done that analysis specifically in New Hampshire, but cost shifting is a well-established phenomenon within hospital finance documented in those two reports here in New Hampshire, and it's known to be a way that unprofitable services are paid for, that impacts on rates are addressed, those types of things.

Q. Indeed, New Hampshire has something of a reputation on its ability to do cost shifting. Isn't that true?

A. I haven't heard of that.

Q. Don't you remember Mr. Norton's reference to the fact that New Hampshire has engaged in effective cost shifting in ways that other states have only recently become aware of?

A. In my experience cost shifting happens in every state. Every state -- Medicaid programs generally pay less than cost in every state, and cost shifting is a way that hospitals in every state address those types of concerns.

Q. But you would agree with me that that's also a finite resource that can contribute to the problem. At some point cost shifting is no longer possible,

correct?

A. Who knows. Hospitals negotiate with managed care plans and attempt to maximize their revenue. I don't know if New Hampshire has reached that point. I don't know if any hospital has reached that point. It's a negotiated outcome that is impossible to predict.

And looking at contracts, that would be for a specific time period. These discussions happen at the point when you have a new contract up for negotiation. That's when the rates would make a -- the rate changes would make a difference.

Q. In any event, that wasn't part of your assignment and you haven't done that work with regard to the hospitals that are in this case, correct?

A. Correct.

Q. Now, with regard to services, there is some point at which the deprivation of funds puts services at risk. Isn't that true?

A. That's true.

Q. In fact, when you've been an expert in other proceedings in other states you've observed that because of the mission of some hospitals their financial condition can be much more dire or worse before they eliminate services because care is central

to their mission. Isn't that an observation you've made in other cases?

A. I believe so, yes.

Q. So it's a fair statement that the deprivation of funds alone is not the only sign of distress -- strike that.

The deprivation of funds can be causing significant harm to a health system long before they reach the point of closure. Isn't that true?

A. That's true if that organization has not implemented efficiencies or made other changes to manage through those problems; that's correct.

Q. Now, the plaintiffs contend in this case that by changes in UPL and DSH $130 million in payments on a year over year basis have been taken from them that would otherwise be used to supplement their Medicaid services. You understand that, right?

A. I understand that the reduction on this chart to revenue would be 130 million. Whether or not those are actually used specifically for Medicaid services is another question. It's just one other part of the revenue base of a health system used for whatever purposes. It's not restricted to be used for Medicaid or any specific purpose.

Q. Okay. But a dollar is a dollar.

THE COURT: But it's tied to Medicaid, right?
Q. It starts from a Medicaid based service, isn't that the case? UPL starts from a Medicaid based service?
A. It's generated by Medicaid utilization, right, and to the extent to which the Medicaid payments are lower than the Medicare rates for a similar service.
Q. It's basically a gap filler. Isn't that right?
A. It is a mechanism to provide revenue to hospitals up to the amount that Medicare would pay for similar services. The difference between what -- I mean, the maximum payment under a UPL mechanism would be the base Medicaid payment plus an amount that could bring it up to what Medicare would pay for a similar service.
THE COURT: Maybe it's a little late for this question, but is it a rate?
Q. Isn't it true that UPL is based on the differential, the rate that is paid through Medicaid up to the rates that would get paid by Medicare? It's a rate gap filler. Isn't that the case?
A. I would think of it as a bucket of money that is calculated based on the average Medicaid rate and

the average Medicare rate. It's not a --

THE COURT: Let me ask you this. If I said it's a Medicaid rate; is it or is it not?

THE WITNESS: It's a Medicaid resource. It's a Medicaid revenue.

THE COURT: It's a Medicaid apple. It's a Medicaid orange. Whatever. Is it a Medicaid rate?

THE WITNESS: I would say, no, it's not a Medicaid rate.

Q. And of course the state desperately does not want it to be a rate in this case because then they have a real problem with the notice they provided. Isn't that true?

A. I would not know that.

Q. Okay. At the end of the day -- let's be clear about the UPL. It starts with a Medicaid service to someone who comes in and is provided that service, and the hospital or the system gets some portion of reimbursement for that service, correct?

A. Correct.

Q. Okay. Now, the hospital takes the difference -- or they report that amount that they've gotten for the Medicaid service, they put it in their cost accounting reports, and it goes into some system, and there's a delta calculated between what's being

reimbursed for that Medicaid service and what Medicare would pay. Isn't that right?

A. There's a what if analysis on the total bucket of activity. What if these services had been paid for at Medicare rates? What would the dollar value of that delta be in total? That's the --

Q. But you're right. Medicare is the higher payer in this transaction. Isn't that the case?

A. It is. And the fact that upper payment limit dollars were available shows that Medicaid rates have been lower than Medicare rates. That's true.

Q. And the Medicare program, that's all set by the federal government, correct?

A. It is.

Q. And the Medicaid reimbursement, the DRG, that's set at the state level, correct?

A. It is.

Q. Just to get back to the point, I don't know if we agree on this or not, and I just want to be clear if we don't. After that service is provided there's a delta that UPL allows the state to use to make up that rate differential between Medicaid and Medicare, true?

A. I would say it's a dollar differential between the value of the services at Medicaid rates

and the value of the services at Medicare rates.

Q. It's reimbursement for services, though. Isn't that the case?

A. It is.

Q. Okay. No one can just say give me UPL if they haven't provided a Medicaid service that they got reimbursed for. Isn't that true?

A. Correct.

Q. As opposed to DSH, which may be based on uncompensated care, which is different. Isn't that true?

A. It is.

Q. Okay. So Medicaid absolutely starts with a Medicaid service. And if anyone tries to get a UPL when they haven't provided a Medicaid service, they can't get it, true?

A. True. It's designed to supplement Medicaid payments.

Q. Now, the second conclusion of your report has to do with the UPL being a one-time event roughly, true?

A. True.

Q. That's your second conclusion. And the sole basis according to your report for that conclusion is a discussion you had with Kathleen Dunn. Isn't that

right?

A. That's correct.

Q. Now, you were in court when Mr. MacDonald was showing the state plan amendments, Exhibit 1 and Exhibit 2, to Ms. Dunn, weren't you?

A. I was.

Q. Now, you hadn't seen those before today, had you?

A. I had not. I saw them yesterday.

Q. You didn't see them before you finalized your report, I guess. Isn't that true?

A. That's correct.

Q. By the way, your report is dated January 4th, right?

A. Yes.

Q. Is that when you finished it?

A. Yeah, it is.

Q. And up to January 4th you hadn't looked at the state plan amendments to verify what you were told by Ms. Dunn about upper payment limit being a one-time deal?

A. Her explanation was that the UPL program was proposed by the hospital association who had a consultant, Health Management Associates, propose the idea that the ARRA program, the American Recovery and

Reinvestment Act, provided an opportunity to take advantage of a higher matching rate which was part of a stimulus package to help the state with economic recovery. And the idea was to continue that UPL program as long as that higher matching rate was available, and that struck me as a logical comment on her part.

Q. And that's where your inquiry ended until yesterday when you saw the state plan amendment that had some different language. Isn't that true?

A. I didn't see anything inconsistent in the state plan amendments -- anything inconsistent with what Ms. Dunn communicated to me.

Q. Sir, you don't think it was inconsistent for the state plan to be filed that said that there would be an annual Medicaid payment?

A. No.

Q. Do you think annual means only one year?

A. The state hoped to continue the UPL payments as long as the ARRA funds, the stimulus funds, were available that may have crossed fiscal periods, which may have meant more than one year.

When it became clear that the ARRA funds were going to terminate, the state put together a new state plan amendment that clarified that this was an annual

one-time resource.

Q. Well, I understand that that's what Ms. Dunn told you, but can you show me where that explanation shows up in the state plan amendment, that anybody who wanted to know what the rules of the game were would find out that it was a one year commitment? Can you point that out, or is it only what Ms. Dunn said to you?

A. Well, it's what Ms. Dunn said to me, and it states here in the state plan amendment that it's an annual payment adjustment.

Q. Annual. And then it goes on to say that -- sorry, my glasses are at home: This payment adjustment is made in addition to all other categories of inpatient services reimbursement otherwise made under the provisions of Section 4.19 A, items 1 through 9. This annual calendar year adjustment payment will be made in the final calendar quarter of each year. Each year.

A. I believe it goes on -- the amendment goes on to say for -- it's time limited. There's something -- I can't remember the exact language but --

Q. Let me put it in front of you so you can see the language that you think is time limiting.

A. Until such time as it may be amended under

the state plan. That's the language. So it was then amended by subsequent state plan amendments.

Q. There was an amendment that turned out it made it one year, but the plan itself gave the state the option to make plans in each year, did it not?

In fact, put it this way -- let me ask another question, Mr. Hearle. If the state decided to make a UPL payment in 2012, they're covered by this SPA that I've just been showing you. Isn't that the case?

A. That SPA has been superseded by a second state plan amendment that would make that not doable.

Q. Okay. So assume that second one wasn't in there. It strikes out all of that annual language and the stuff. The one I'm showing you right now, if this were in place today, if this were the state plan the state would be able to make an upper payment limit and there would be no need for an amendment. Isn't that true?

A. If this were the state plan language in effect, if it hadn't been superseded by a second plan amendment, then yes, they would have had the ability to continue making those payments.

Q. You did some triangulation of data from the hospitals on Medicare cost reports. Sir, you don't

know, like you didn't know with the Schedule Hs, whether the non-hospital affiliated numbers were included in those Medicare cost reports, do you?

A. I know that they were not because the cost reports are filed only by the hospital operations, the provider numbers for each hospital.

Q. So there's an easy explanation. We've got hospital systems here for the most part that are plaintiffs, and you know just by definition that the numbers that you are trying to triangulate don't have their non-hospital affiliate numbers in it, true?

A. That's true. I'm comparing one set of numbers that are specifically mentioned in the declarations, the hospital outpatient cost numbers, with other hospital cost report numbers that were filed with the state. So it is apples and apples based on the way it was described.

Q. When do hospitals file their cost reports, on their own fiscal year or on a set schedule?

A. I believe it's on their own fiscal year. Within 90 days of the end of that year. And then there's a process of having them reviewed and audited by intermediaries.

Q. Going back to UPL for a second, you suggested that the hospitals -- some of the tables you were

looking at -- I think you might have one in front of you. I don't mean to look over your shoulder.

MS. O'CONNELL: Would you pull Exhibit 79 up?

Q. Would you look at that for a minute?

A. Yes.

Q. You suggested that this table improperly carries some UPL references for 12 and 13. Do you see that?

A. I do.

Q. All right. Now, you had some criticisms in your report of last Friday, some of which are addressed by Exhibit 79. Isn't that true?

A. That's true. The UPL number in 2011, which was a negative number in the original declarations, then became a zero in the second -- in the supplementary declarations is not now positive in this exhibit.

Q. So that is reflecting in this example an upper payment limit payment in 2011 to Lakes Region General, and that's offsetting the other expenses listed above, true?

A. That's the way I would think about it.

Q. Okay. That's consistent with your analysis. That's how you would recommend somebody carry that if they're going to represent that number, true?

A. If I were reviewing a summary of rate reductions and included upper payment limit, that resource in that table, then yes, I would put them all together in this way.

Q. Okay. Now, your quarrel is that because of your understanding that it was a one year situation and that the state had no obligations under a state plan to do an amendment, or any of those types of things, it shouldn't be carried in 12 and 13; is that right?

A. It shouldn't be carried as a negative number. In my career I've done hundreds of hospital financial models for feasibility studies for different types of assessments. And if I were modeling out the net impact of these changes on an organization what I would do is have the upper payment limit revenue come in as a positive in 2011 and then come in as a zero in 2012 and 2013.

Q. Well, okay. What if you're a hospital plaintiff in this case and you read the state plan amendment that said UPL is going to get an annual payment, the language I just showed you, wouldn't it be reasonable and prudent to include it in your assessment until there's a state plan amendment filed to remove it, or should we rely on, you know, the

comments of the director informally to a witness like you?

A. Can you restate that, please?

Q. Sure. If you're a hospital plaintiff in this case, isn't it reasonable, looking at a state plan amendment that says annual UPL payments will be made until such time as they are amended and taken out, I'm paraphrasing, isn't it reasonable to model that in the financial impacts?

A. The way I would then model it is to have the 4.1 million in as a revenue in each of these three years. And if I thought it was going away, then I would have the number backed out. So I would have the 4.1 positive, 4.1 positive, 4.1 positive, and then show the negative 4.1, in the event it would be lost, so the net effect would be zero. That's how I would describe it in the table.

Q. But that assumes a payment in the reduction, not the loss of a payment.

THE COURT: That's what the state did in reverse with the tax.

MR. O'CONNELL: I'll move on.

THE COURT: His point is, if you're not going to get it, you don't count it as having gotten it and then offset it out for not getting it. You just say

you didn't get it, right?

THE WITNESS: Right.

THE COURT: But this isn't to show what your financial projection is. This is to show an impact that you didn't expect to have.

MR. O'CONNELL: Just impact. Impact.

Q. You didn't understand this to be a damage claim, did you, Mr. Hearle?

A. I understood this to be an impact. So as I project out -- if I were CFO and I projected out the impact of these on my revenue stream, I would say I had a positive event in 2011 and a zero event in 2012 and 13.

Q. That's how you would do it?

A. That's how I would do it.

Q. Okay. You talked about the wherewithal of New Hampshire hospitals because of positive margin, and you had a number and a table that Ms. Smith asked you about. Do you remember that, generally?

A. I'm sorry?

Q. You were asked questions about hospital margins by Ms. Smith.

A. I was.

Q. That's another example, is it not, where you looked just at the data of hospitals and not the

health system, true?

A. I looked at both. The audited financial statements are for the systems. That includes all the activities included in those audited financials.

Q. And that's table 8?

A. It is.

Q. Okay. And that's half the margin from what you report in table 7?

A. For 2009, yes. That's correct.

Q. Would you tell me, sir -- you've done a lot of work on assessment of reimbursement rates to comply with Medicaid. Isn't that true?

A. I have assessed Medicaid payment issues in several states, yes.

Q. You've been an expert retained to do that and provide advice?

A. I've been an advisor to state hospital associations on that topic, yes. Not in litigation.

Q. You did an assessment for Oregon?

A. Correct.

Q. You did an assessment for Massachusetts?

A. Yes. For the Governor's office.

Q. In connection with those assessments you didn't include any analysis of the profitability of hospitals or health systems to assess the adequacy of

Medicaid funding. Isn't that true?

A. I believe I did project out the impact of Medicaid payment on the hospitals' margins in those states. It's been several years since I did those studies.

Q. Fair enough. If we need to look at them, we will, but let me ask you this. The point of your analysis wasn't to suggest that hospitals could pay and subsidize the Medicaid. You were simply modeling the impacts over time of different types of reimbursements. Isn't that fair to say?

A. Correct.

Q. So this is a different exercise than you did for Massachusetts and Oregon, stating a proposition that, well, hospitals have a positive margin and they can afford to subsidize Medicaid. It's different here than there; isn't that right?

A. I'm not sure how.

Q. Well, your point of view is that hospitals are in a better position to absorb Medicaid losses than other states.

A. The point of view is that historically the hospitals have been more profitable in New Hampshire than hospitals in other states, and that is after many of these rate reductions already were implemented.

Q. Well, my question is on 30(a), that you're familiar with from all this work that you've done. Where does 30(a) allow this Court, or CMS, or anybody who is going to look at the adequacy of rates, to look at the financial margin of the provider?

A. I'm actually not familiar with --

MS. SMITH: I'm going to object. That calls for a legal conclusion. He's not here as a legal expert.

THE COURT: I agree. Sustained.

Q. I will withdraw it and ask: Are you familiar, sir, with -- in any circumstance in which you've provided counseling, Oregon, Massachusetts, where the standard that you're trying to meet was the profitability of a hospital to absorb more Medicaid losses?

A. I'm familiar with assessing the impact of Medicaid payment on hospital margins. I'm also familiar that state Medicaid agencies do consider the financial performance of providers when they consider rate issues.

Q. You've said before that the point of the Medicaid program in evaluating the equity and performance of a payment system, such as Medicaid, that the payment rates are high enough to encourage

payment participation by efficient providers, true?
A. Yes, I believe I said that.
Q. Ensure access to beneficiaries/enrollees in all markets and to the general population in local markets, true?
A. If you're reading from one of my reports that probably is ten years old.
Q. Sure.
A. I probably did say those things.
Q. One second.
A. Which report is it?
Q. Oregon. February 26, 2003. Is this your report, sir?
A. It's a report prepared by the Lewin Group. I was the lead analyst working on the report, yes.
Q. And you remarked in that context that the payment system should do what I was just describing, among other things. Let me show you the language just so you can verify it.
THE COURT: Is this all heading to his opinion on whether or not profitability should be considered?
MR. O'CONNELL: Yes. Okay. I'll move on.
THE COURT: Do you have much more to go?
MR. O'CONNELL: No.

THE COURT: Because I assume you have a plane to catch, Mr. Hearle.

THE WITNESS: I do, yes.

THE COURT: The court reporter has been kind of going along for more than two hours, which is probably against the union.

MR. O'CONNELL: I understand, your Honor.

Q. The last point, charitable benefits. These ten hospitals provided, based on the state's own numbers, 177 million in uncompensated care in fiscal year 2012; is that right?

A. That's what the exhibit shows, yes.

Q. Do you have any reason to doubt that?

A. No.

Q. That's a lot of community benefit, isn't it?

A. Typically to figure out if it's a lot you denominate it by the total expenses of the organization. So it's a percent of the expense, what percent of the budget is being used for those purposes, and that's not portrayed here.

Q. So you don't know? You don't have an opinion on that?

A. I don't have the denominators to say if that's a lot compared to other standards that I'm aware of.

MR. O'CONNELL: One second. I have no further questions, your Honor. Thank you.

THE COURT: Any redirect?

MS. SMITH: Just a few. First I want to ask Attorney O'Connell if you will agree to strike the ID on Mr. Hearle's report.

MR. O'CONNELL: Oh, I will not. It's got a lot of hearsay. I think he's testified to the tables, and there's a lot of things in there that are objectionable.

REDIRECT EXAMINATION

BY MS. SMITH:

Q. Just to get back to a couple of the questions that Attorney O'Connell asked you. He asked you a lot of questions about why didn't you review source data from the hospital.

Did you understand that at this point we were in a preliminary injunction stage and we have not conducted discovery, therefore the state has just had no opportunity to ask for that data yet?

A. I understand that, yes.

Q. And is that -- strike that. In regards to these total numbers that Attorney O'Connell was talking about the affect of the 2011 changes, you understand that DSH includes not just the Medicaid

losses but also uninsured?

A. I do.

Q. And if you could, from the white notebooks behind you and what's being put up on the screen, look at Exhibit 120?

A. Which binder might it be in?

Q. It's probably either 2 or binder 3. It's binder No. 2.

A. There's no 120 in here.

Q. I have it. Here. Let me just hand you a paper copy of it.

A. Thank you.

Q. Were you provided a complete set of the exhibits that had been attached by the defendant to the preliminary injunction motion?

A. I'm not sure if I was.

Q. Can you just look at that and tell me if you recall seeing it before?

A. I do recall seeing this, yes.

Q. Okay. So this is one of the documents that you had reviewed?

A. Yes.

Q. And you remember that you said that Ms. Dunn had told you that the UPL was a one-time payment that had been suggested by the hospital association's

consultant?

A. That's what I recall, yes.

Q. If you can look at that, is that the hospital association's consultant that she was telling you about?

A. Yes. Health Management Associates.

Q. And in that does the hospital consultant recognize that this UPL payment is a one-time thing?

A. The paper speaks to the enhanced Medicaid matching rate on page 2. It says: While the enhanced Medicaid matching rate provided through the stimulus bill is set to expire December 31, 2010, the House healthcare reform bill included an extension. If that's included, so and so.

Q. And then below that does it say: But this is a one-time event?

A. Yes. I do see below that it speaks to it being a one-time solution: It is important to note that all of the approaches described above represent one-time solutions for the funding shortfall.

Q. So in the question that Attorney O'Connell asked you about, if the hospital CEO could reasonably have expected UPL, do you think it was reasonable to expect UPL to continue when their own consultant had suggested it as a one-time solution?

A. If the CEO had read this report, then I would assume not.

MS. SMITH: I don't have any further questions.

THE COURT: All right. Thank you.

MR. O'CONNELL: I do.

THE COURT: All right.

MR. O'CONNELL: Thank you, your Honor.

RECROSS-EXAMINATION

BY MR. O'CONNELL:

Q. Would you keep that document in front of you, sir? This document where it says it's a one-time solution is directly under a heading that says Enhanced Medicaid Matching Rate. Do you see that?

A. I do.

Q. That's not UPL. That was special to the stimulus plan in that year. Isn't that true?

A. It is. But it provided the opportunity to engage in the one-time solution.

Q. There's nothing that stopped the state of New Hampshire from paying UPL this year except an appropriation for it. Isn't that true?

A. I don't know the answer to that.

MR. O'CONNELL: Thank you. Nothing further, your Honor.

THE COURT: Thank you, sir. You can step down. You're excused. And why don't we take a ten minute break.

(RECESS)

THE COURT: All right. Where were we, Ms. Smith?

MS. SMITH: Attorney MacDonald had finished his testimony with Ms. Dunn, and I was going to start mine.

THE COURT: All right. I assume you want to go Friday? I assume you wish to resume Friday?

MR. MACDONALD: Yes.

MS. SMITH: Yes.

THE COURT: 9:00 o'clock?

MS. SMITH: Yes.

THE COURT: Just a few hours?

MR. O'CONNELL: Yes.

MS. SMITH: We're assuming we have all day on Friday?

THE COURT: Do you really need it? Well, I'll see. We'll see.

MS. SMITH: We still have a number of witnesses that haven't been called.

THE COURT: I'll at least give you all the time that I've used up myself. Let's do it that way.

CROSS-EXAMINATION OF KATHLEEN DUNN

BY MS. SMITH:

Q. Ms. Dunn, you've been asked a lot of questions in the last couple of days about various state plan amendments that have been submitted. And let me bring up to you to show you so that we can be looking at the same page, it's Exhibit 173, and the defendant's exhibit which is the same one the plaintiffs have marked as well.

Looking at the front of this, this is the composite section of the state plan that is 4.19 B, and that deals with outpatient services, correct?

A. Yes, it does.

Q. Okay. When you submit a state plan, is there some lag time usually before it's approved by CMS?

A. Yes, there is. CMS has 90 days to review the submittal, and at that time they have to either approve the state plan amendment or send a request for additional information back to the state.

Q. And then what happens in that process after they send the request for additional information back to the state?

A. CMS starts a 90-day clock, and it requires the state to provide answers to the questions. If the request for additional information -- during that

time -- I'm sorry -- during that time you answer questions from CMS even by phone, et cetera, e-mails they'll send us, and if CMS believes that we're going to go past the 90-day clock, they will pull the state plan amendment what they call off the clock. And at that point they want to work with the state in order to resolve whatever issues need to be resolved. It goes back on the clock and gets approved.

Q. So what is the ability -- can the state implement a proposed state plan before CMS approves it?

A. Yes, except in one instance. And that is if you're going to implement Medicaid managed care, you have to have your state plan approved before you can actually roll the program out. Otherwise your state plan amendment has to be filed by the last day of the quarter which you wanted the state plan to be effective.

Q. And in regards to some of these state plans that we see in Exhibit 173, and I'm going to take you to I believe it's page 12 of 57 in that document as just an example, how long did it take to get that state plan approved through CMS?

A. This was submitted in 2007. It's 07-010 at the bottom. It was finally approved by CMS on June

24th of 2010.

Q. So it took over three years for that one?

A. It did.

Q. And how does -- let me just ask regarding a specific state plan. We looked before at state plan 06-008 and we were on page 1, and this is page 6 of 57 in Exhibit 173. Is that state plan still pending with CMS?

A. Yes, it is.

Q. And I think you were asked questions either earlier today or yesterday about when this page was first submitted and you were shown what has been marked as --

MR. MACDONALD: Plaintiff's 92.

MS. SMITH: Pardon?

MR. MACDONALD: Plaintiff's 92. I'm sorry. 96.

MS. SMITH: It's Plaintiff's Exhibit 96.

Q. Do you remember looking at that earlier today?

A. Yes, I do.

Q. I believe that Mr. MacDonald told you that the first time -- that when this page 1 that we're looking at in Exhibit 173 was submitted in response to request for admissions -- not request for admissions,

I'm sorry -- the RAIs, the request for additional information, this was submitted by the department to CMS in a transmittal that's in that document on November 20, 2008, correct?

A. Yes. This was responding to the request for additional information on that 06-008.

Q. And so this page had been submitted to CMS -- had this page been submitted to CMS before the November 21, 2008, fiscal committee meeting?

A. Yes.

Q. And what is your understanding as to whether or not you could operate under the language that was in paragraph 1 in this page on November 21, 2008?

A. It was my understanding that -- because we had a pending state plan amendment, that until it is disapproved by CMS that we were able to operate underneath it.

Q. And was this same language that was in paragraph 1 submitted as part of subsequent SPAs that also affected that page?

A. Yes.

Q. And can you look through this and tell me if that language is still in the page 1 that is currently pending for review before CMS?

THE COURT: Which language is this related

to?

MS. SMITH: I'm looking specifically at the first paragraph of page 1 and 4.19 B, first paragraph of paragraph 1.

THE COURT: Is it here? No, it's not.

MR. O'CONNELL: We have a technology issue, your Honor. We are running it currently. Oh, you've got it, okay. No? 96?

MS. SMITH: We're on Exhibit 173.

MR. O'CONNELL: I'm sorry. I think we solved it.

THE COURT: Okay. Thanks.

A. On the page of the exhibit at the top right-hand corner it's labeled page 2 of 57. It is transmittal number 10-014, a state plan amendment submitted in 2010, and the -- if you look at number 1 where it says Outpatient Hospital Services, the first paragraph looks to be exactly the same from the 06-008.

Q. And going back to the prior SPA that we were talking about that you may be withdrawing that was 08-017, that also contained the same language in the first paragraph of paragraph 1, correct?

A. It did.

Q. And there's actually been -- has there been a

subsequent page of this filed more recently than what's in here?

A. Yes. We had to file a state plan amendment to be able to meet the changes in the DSH program so that we could make payments in December to the critical access hospitals. So the prefix starts with an 11.

Q. It's in the notebooks behind you I believe as Exhibit 194 or 195. Actually, it's 195.

A. Yes.

Q. So that same language that we saw starting back in 06-008 in paragraph 1 that was discussed as being a clarification of the existing methodology has continued in each of the SPAs that have been submitted down to this one, which is 11-007?

A. Correct.

Q. And what is the methodology described in that paragraph as far as setting outpatient rates?

A. The current -- the 11-007 says that an interim payment shall be made based on percent of charges. Final payment is made in accordance with the percent of costs. An audit of each hospital's actual costs eligible for reimbursement shall be performed by the fiscal intermediary in accordance with federal Medicare requirements. The department shall determine

the percent of actual costs to be reimbursed. And then payments made to the hospital in the previous year shall be cost settled using the percent determined by the department and the actual cost data audited by the fiscal intermediary.

Q. What does that language provide as far as the department's ability to adjust the percentage applied to cost reimbursement if your budget is insufficient to cover the services?

A. I believe the language provides that the department will determine what the percent of actual costs are to be paid -- excuse me -- to be reimbursed. And so ultimately the department's determination is based upon the funding made available by the legislature.

Q. At what page -- what version of this page, which has been referred to as the reimbursement page, do you believe you had the right to operate under on November 21, 2008?

A. I believe that I had the ability to operate under the very first one, the 06-008.

MS. SMITH: I could probably start another line of questioning, your Honor. I can do that, or we can break till Friday.

THE COURT: Well, we have to be out before

5:00 anyway. All right. Why don't we do that. Why don't we just take a few minutes -- you can step down, if you would like, Ms. Dunn, I appreciate it -- since we have a few minutes.

Maybe this already exists somewhere in an exhibit, but I'm starting to get lost about the nefarious rates settled.

Outpatient radiology, that's a rate reduction? That's part of your claim?

MR. MACDONALD: It's a rate reduction. I believe --

THE COURT: Good. If you don't know, then I feel better about not knowing.

MR. MACDONALD: It is a rate reduction, yes.

THE COURT: That's part of your claim?

MR. MACDONALD: It is part of the claim, but there was testimony -- I was just going to say there was testimony you heard today from Ms. Dunn which is that they are no longer enforcing that rate reduction and they're going to pay -- refer back to a cost schedule. I'm just trying to make --

MS. SMITH: And recalculate all of the payments before that.

THE COURT: So that's just an example of -- you're just throwing that in as an example of a

similar violation.

MR. MACDONALD: Your Honor, we pled that in our complaint filed in July.

THE COURT: They changed their mind.

MR. MACDONALD: They changed their mind in January.

THE COURT: A revenue code 5 payment?

MR. MACDONALD: Yes.

THE COURT: That's a rate reduction that you claim is improper.

MR. MACDONALD: That's correct.

THE COURT: Improperly noticed. Let's just use this for my benefit. Let's just think 13(A). Outpatient cost settlement, a claim?

MR. MACDONALD: Rate reduction.

THE COURT: Rate reduction claim?

MR. MACDONALD: Yes.

THE COURT: Inpatient UPL payment?

MR. MACDONALD: Yes.

THE COURT: You claim that's a rate reduction?

MR. MACDONALD: Yes.

THE COURT: So outpatient UPL payment, the same thing?

MR. MACDONALD: Yes.

THE COURT: DSH payment, reduction, eliminate, you claim that's a rate reduction?

MR. MACDONALD: It's a change in the methodology of the state plan. We cannot claim it's part of the rates.

THE COURT: So how does it come under your claim? You claim it's a failure to give adequate notice and opportunity to make comment on a change to the state plan, 13(A)?

MR. MACDONALD: Yeah.

THE COURT: And the catastrophic payments?

MR. MACDONALD: That's a rate reduction. Yes, your Honor.

THE COURT: All right. I'm getting the impression that there is some -- your position is that some of these things were noticed?

MS. SMITH: Correct.

THE COURT: After the fact kind of?

MS. SMITH: Well --

THE COURT: You know, I've been looking at Judge Tauro's case out of Massachusetts and the Hood case out of the Fifth Circuit, and I'm looking at those models as sort of analytical models and they're pretty clear.

The first question obviously is: Do you have

to give public notice? Is it a rate reduction or is it a methodology change? Do you? If you did, what did you do? And are you claiming that some of these changes, amendments -- state plan amendments were noticed and by publication of notices in newspapers?

MS. SMITH: Yes.

THE COURT: Some of these that I've just outlined?

MS. SMITH: Yes.

THE COURT: Okay. After the fact? Before the fact?

MS. SMITH: Before the fact.

THE COURT: Okay. At some point I think I'm going to want a compilation of, here are my claims. These are the improper rate reductions. This is what we say forms the basis of our claim that they're unlawful.

And I would like the state to give me a column that says, this is our claim as to why they were properly noticed or didn't have to be noticed or whatever. And then I get the impression that your claims are sort of -- I'm not sure what they are. You seem to have some claims out there -- well, I lost the thought. Well, you can't help me.

MR. MACDONALD: May I, your Honor? Just on

that list we would also include the outpatient rate reduction.

THE COURT: The outpatient rate reduction, right.

MR. MACDONALD: And the inpatient rate reduction. So the --

THE COURT: Oh, I'm sorry. Right, right, right. Sure. Yes. And then that's different because that's -- one is apparently subject to an unchallenged state plan amendment, the inpatient, as I recall, and the question is -- that's what I was thinking. The question is what does it mean, right?

MR. MACDONALD: That state plan amendment, whether it was sufficient.

THE COURT: Well, in my mind first it's what does it mean, and secondly -- that's what I was thinking. You have a claim that -- I gather for the inpatient you've got a claim that either it was changed, in which case it wasn't properly noticed, or if you take the state at its word, they just clarified it, they didn't change anything, in which case they didn't apply it properly.

MR. MACDONALD: That's exactly right for outpatient.

THE COURT: Outpatient. Okay. I'm sorry.

Inpatient is, what does it mean when it says adjust minus state budget neutrality factor, and I suppose then what? Can you do that?

MR. MACDONALD: And then we showed you an example --

THE COURT: No. Is that the issue? Can you do that?

MR. MACDONALD: No, you can't.

MR. CHAPMAN: That's the issue.

THE COURT: This is the one that says, here's the methodology for receiving the rate. We're going to jump through all these hoops. We're going to have a very complicated formula. We're going to assess everything. Then we're going to set the rate based upon what money we have. That one?

MR. O'CONNELL: That one, yes.

THE COURT: There's no claim that that was not properly noticed, right?

MR. O'CONNELL: Yes, there is that claim.

THE COURT: Oh, there is?

MR. MACDONALD: That was the -- we're talking about the inpatient rate?

THE COURT: Right.

MR. MACDONALD: That was the rate reduction that took place when the Governor signed the executive

order and marched over to the legislative office building and presented it at 9:00 a.m. the same day, and there was no notice whatsoever, and I think Ms. Dunn testified to that.

THE COURT: I got that. But didn't the state plan provide at that time that the rate would be calculated according to a methodology that included adjusting for state budget neutrality factor?

MR. MACDONALD: That is a legal issue. We claim --

THE COURT: But that's a yes?

MR. MACDONALD: Yes.

THE COURT: Okay. So then doesn't the issue really arise as, did they comply with the state plan?

What if the state plan properly interpreted says, here's our method, our method is whatever money we have we're going to adjust the rates in order to achieve that goal of spending no more than that? Can you have a plan that says that?

MR. MACDONALD: I don't believe so, your Honor. I don't think that's considered --

THE COURT: Because that's far different from a 13(A) claim of I didn't get notice. That's more a 30(a) claim of you're not doing it right.

MR. MACDONALD: Your confusion -- or the

confusion around --

THE COURT: Yeah, it's confusion. It's confusion.

MR. MACDONALD: There are really two notice requirements here. One is 13(A).

THE COURT: Uh-huh.

MR. MACDONALD: And that deals with rates. And they need to be published and the justifications need to be articulated.

The second is, when you change the state plan that's subject to a notice as well.

THE COURT: Uh-huh.

MR. MACDONALD: And so on this particular example the plaintiffs contend that 13(A) could never have been satisfied because the manner in which the rate reduction was effected. In other words, the Governor signing the executive order, going over to joint fiscal, and getting it approved within minutes. Never noticed. It just happened. That's the violation of 13(A).

THE COURT: Why is it if that is what the plan says the proper methodology consists of?

MR. MACDONALD: Because --

THE COURT: Say the plan said the methodology we're going to use is this. There's going to come a

time when the Governor is going to determine how much money to recommend the legislature appropriate, and there's going to come a time the legislature is going to appropriate that amount. And whatever that amount allows the rate to be, that's going to be the rate.

MR. MACDONALD: Well, I still think the state has an obligation to publish the rates and whatever their justifications are. That's what 13(A) says. That's what 13(A) says.

Now, if I may while we're on this rate reduction, I just want you to understand -- the Court to understand that we also contend that the state plan does not support an across the board rate reduction as it's written. And our evidence there was pointing to a prior instance where they had to achieve an across the board rate reduction and they sought a state plan amendment to do so.

THE COURT: Oh, sure. Right, right. You've offered that just as sort of an example of how it's supposed to be done and an admission that they understood that.

MR. MACDONALD: Exactly.

THE COURT: All right. Okay. Any questions for me? Are we all set? 9:00 o'clock Friday?

MS. SMITH: 9:00 o'clock.

THE COURT: Let's try to do it in a half day if we can. Do you really have a lot? What are your witnesses going to be?

MS. SMITH: We haven't finished Ms. Dunn yet, who was the last of their witnesses.

THE COURT: Right.

MS. SMITH: We also had just discussed that we will confer tomorrow morning about who else they plan on calling. They have several other witnesses of ours that are on their list. If they don't call those, we will then decide which of our witnesses we still have to call after Ms. Dunn. But we did have the finance director, Marilee Nihan, as well as a couple other witnesses on our list.

MR. MACDONALD: Your Honor, we're very mindful of the principles of the timely efficiency, quality of life, and we'll work together to streamline things.

THE COURT: If you can -- I don't want to put too much more of a burden on you, but I think it will be time well spent -- what I just outlined by way of a chart would be really helpful. You don't have to do a rendition of all of the -- you know, starting with the Magna Carta and everything, but a chart would be very helpful.

MR. MACDONALD: I actually have a little cheat sheet right here.

THE COURT: Yeah, a chart would be very helpful as to exactly what your claims are with respect to 13(A) particularly and 30(a) somewhat.

MR. O'CONNELL: Would you like that conventionally filed, or do you want it through ECF?

THE COURT: Oh, either one.

MR. O'CONNELL: Just bring it to court?

THE COURT: Sure. I assume you're on the same page as to who is claiming what and what they're claiming?

MS. SMITH: They have some things on their charts we don't think are in their claim. As long as they don't put that on their chart, we may be on the same page.

THE COURT: Well, maybe you could do the same thing then. Again, just a chart. Not a big memo or anything. Just a chart saying, you know, this is their 13(A) claim with respect to inpatient rate reduction. This is why -- this is our notice. This is where we published. This is what we published. It's what it says. Done.

MS. SMITH: We've already discussed working on that tomorrow.

THE COURT: Great. Thank you very much. I appreciate it.

MR. O'CONNELL: Thank you, your Honor.

THE COURT: Have a good day.

(Conclusion of hearing at 4:55 p.m.)

C E R T I F I C A T E

I, Susan M. Bateman, do hereby certify that the foregoing transcript is a true and accurate transcription of the within proceedings, to the best of my knowledge, skill, ability and belief.

Submitted: 1-23-11

Susan M. Bateman

SUSAN M. BATEMAN, LCR, RPR, CRR
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